CHAPTER II

PROVIDER PARTICIPATION REQUIREMENTS

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PARTICIPATING PERSONAL/RESPITE CARE PROVIDER

A participating personal/respite care provider is an institution, facility, agency, partnership, corporation, or association that meets the standards and requirements set forth by the Department of Medical Assistance Services (DMAS) and has a current, signed participation agreement with DMAS (see "Exhibits" at the end of this chapter for a sample of this form). Personal care and respite care are two services offered through the Elderly and Disabled Waiver. The duties and responsibilities of the provider are the same for both services. Each service requires a separate participation agreement and provider identification (ID) number. The term personal/respite care is used throughout this manual wherever procedures and policies are alike for both services. A provider may, however, choose to offer only one of the two services.

Personal/respite care providers provide services designed to prevent or reduce institutional care by providing eligible recipients with personal/respite care aides who perform basic health-related services. This chapter sets forth the requirements for approval to participate as a Medicaid provider of personal/respite care as a part of the Elderly and Disabled Waiver. The personal/respite care provider will be reimbursed according to the fee schedule outlined in Chapter V. Any provider contracting with Medicaid to provide these services agrees as part of the provider participation agreement to adhere to all the policies and procedures in this provider manual.

PARTICIPATING ADULT DAY HEALTH CARE PROVIDER

A participating Adult Day Health Care (ADHC) provider is an institution, facility, agency, partnership, corporation, or association that is licensed by the Virginia Department of Social Services (DSS) as an Adult Day Care Center, meets the standards and requirements set forth by DMAS, and has a current, signed participation agreement with DMAS (see "Exhibits" at the end of this chapter for a sample of this form).

Adult Day Health Care Centers (ADHCs) offer community-based day programs providing a variety of health, therapeutic, and social services designed to meet the specialized needs of elderly and physically disabled recipients who are at risk of being placed in a nursing facility. ADHC Services enable recipients to remain in their communities and to function at their highest level possible by augmenting the social support system already available to the recipient, rather than replacing the support system with more expensive institutional care. The ADHC Center will be reimbursed according to the fee schedule outlined in Chapter V. Any provider contracting with Medicaid to provide these services agrees as part of the provider participation agreement to adhere to all the policies and procedures in this provider manual.

PARTICIPATING PERSONAL EMERGENCY RESPONSE SYSTEM PROVIDER

A participating personal emergency response system (PERS) provider is a certified home health or personal care agency, a durable medical equipment (DME) provider, a hospital, or a PERS manufacturer that has the ability to provide PERS equipment, direct services (i.e., installation, equipment maintenance and service calls), and PERS monitoring. The PERS provider must meet the standards and requirements set forth by DMAS, and have a current, signed participation agreement with DMAS (see "Exhibits" at the end of this chapter for a sample of this form.) All PERS providers must enroll as DME providers in order to provide this service to Medicaid recipients and to receive reimbursement from Medicaid. Enrollment as a DME provider does not obligate the PERS provider to provide any other DME services. The agency designated in the Participation Agreement must directly provide the services and bill DMAS for Medicaid reimbursement.

PERS services are designed to prevent or reduce inappropriate institutional care by providing eligible recipients with services which will allow them to live independently while having access to emergency services. This chapter specifies the requirements for approval to participate as a Medicaid provider of the PERS services as a part of the Elderly and Disabled Waiver. The PERS provider will be reimbursed according to the fee schedule outlined in Chapter V. Any provider contracting with Medicaid to provide services agrees as part of the provider participation agreement to adhere to all the policies and procedures in this provider manual.

PROVIDER ENROLLMENT

Any provider of services must be enrolled in the Medicaid Program prior to billing DMAS for any services provided to Medicaid recipients. The provider, interested in becoming a Medicaid provider, must submit a letter to First Health Services - Provider Enrollment Unit (FHS-PEU) requesting a provider participation agreement. Requests will be screened to determine whether the applicant meets the basic requirements for participation. An application will be mailed to any interested party who meets the basic requirements for participation.

FHS-PEU will review the documentation from the provider that verifies provider qualifications. If the provider meets the qualifications as outlined in this chapter, FHS-PEU will send the provider notification that the application has been approved. The provider must maintain documentation (including relevant license, personnel records, etc.) that verifies the provider's qualifications for review by DMAS staff.

Upon receipt of the signed participation agreement and verification of approval, FHS-PEU returns a copy of the signed participation agreement to the provider and assigns a provider number. DMAS will not reimburse the provider for any services rendered prior to the assignment of this provider identification number (ID). This number must be used on all claims and correspondence submitted to the Medicaid Program.

If the provider wishes to open another agency or office in a different part of the State, the provider must obtain a new ID number for the new agency prior to initiating services in that area. A provider may not bill DMAS for services provided at one agency branch using

the ID number of another agency branch. Providers will have a different ID number for each type of service (Personal Care, Respite Care, etc.) provided.

This manual contains instructions for billing and specific details concerning the Medicaid Program. Providers must comply with all sections of this manual to maintain continuous participation in the Medicaid Program.

Providers may request participation agreement(s) by writing, calling, or faxing a request to:

First Health
VMAP-PEU
P.O. Box 26803
Richmond, VA 23261-6803

Phone: (804) 270-5105
Fax (804) 270-7027
Toll-free in state only 1-888-829-5373

PARTICIPATION REQUIREMENTS

All providers enrolled in the Virginia Medicaid Program must adhere to the conditions of participation outlined in their participation agreements and must perform the following activities as well as any other specified by DMAS:

- Immediately notify DMAS, and the First Health Provider Enrollment Unit (FH-PEU), in writing, of any change in the information which the provider previously submitted to DMAS or FH-PEU. This includes any change in provider status (location, mailing and payment address, etc) as well as any change in a recipient's condition or level of service delivery as outlined in the policies in this manual.

- Assure freedom of choice to recipients in seeking medical care from any institution, pharmacy, practitioner, or other provider qualified to perform the service(s) required and participating in the Medicaid Program at the time the service is performed.

- Assure the recipient's freedom to reject medical care and treatment.

- Accept referrals for services only when staff is available to initiate services.

- Comply with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. 2000d through 2000d-4a), which requires that no person be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the grounds of race, color, or national origin.

- Provide services, goods, and supplies to recipients in full compliance with the requirements of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794),

which states that no otherwise qualified individual with a disability shall, solely by reason of his or her disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Rehabilitation Act of 1973, as amended, requires reasonable accommodations for certain persons with disabilities.

- Provide services and supplies to recipients in the same quality and in the same mode of delivery as provided to the general public.

- Charge DMAS for the provision of services to recipients in amounts not to exceed the provider's usual and customary charges to the general public.

- Not require, as a precondition for admission or continued stay, any period of private pay or a deposit from the patient or any other party.

- Accept Medicaid payment from the first day of eligibility.

- Accept as payment in full the amount established by DMAS to be reasonable cost or maximum allowable charge. 42 CFR, Section 447.15, provides that a "State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency." A provider may not bill a recipient for a covered service regardless of whether the provider received payment from the state. The provider may not seek to collect from a Medicaid recipient, or any financially responsible relative or representative of that recipient, any amount that exceeds the established Medicaid allowance for the service rendered.

  Example: If a third party payer reimburses $5 out of an $8 charge, and Medicaid's allowance is $5, then payment in full of the Medicaid allowance has been made.

  Providers cannot bill recipients or DMAS for broken or missed appointments.

- Accept assignment of Medicare benefits for eligible Medicaid recipients.

- Use Program-designated billing forms for submission of charges.

- Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the health care provided. Such records shall be maintained in a designated business office from which all provider business is conducted.

- Such records must be retained for a period of not less than five years from the last date of service or as provided by applicable State laws, whichever period is longer. If an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved.

Records of minors must be kept for at least five (5) years after such minor has reached the age of 18 years.

- Policies regarding the retention of records shall apply even if the agency discontinues operation. DMAS must be notified in writing of the storage, location, and procedures for obtaining records for review should the need arise. The location, agent, or trustee should be within the Commonwealth of Virginia.

- Furnish to authorized State and federal personnel, in the form and manner requested, access to records and facilities.

- Disclose, as requested by DMAS, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to recipients of Medicaid.

- When ownership of the provider changes, DMAS shall be notified within 15 calendar days in writing.

- Hold confidential and use only for authorized DMAS purposes all medical assistance information regarding recipients. A provider shall disclose information in his or her possession only when the information is used in conjunction with a claim for health benefits or the data is necessary for the functioning of DMAS. DMAS shall not disclose medical information to the public.

- Employ and supervise professionally trained staff meeting the requirements stated in this chapter.

- Assure that no processing of bankruptcy or financial insolvency has been adjudicated or is pending in any state or federal court and agree to inform DMAS of any action instituted with respect to financial solvency.

RECIPIENT CHOICE OF PROVIDER

If services are authorized and there is more than one approved provider in the community, the recipient will have the option of selecting the provider of his or her choice.

PROVIDER PARTICIPATION STANDARDS FOR PERSONAL/RESPITE CARE SERVICES

In addition to the above, to be enrolled as a Medicaid personal/respite care provider and maintain provider status, an agency must meet the following special participation conditions:

Staffing Requirements

1. Registered Nurse

The provider must employ (or subcontract) and directly supervise a Registered Nurse (RN) who will provide ongoing supervision of all personal/respite care aides. The RN must be currently licensed to practice in the Commonwealth of Virginia and have at least two (2) years of related clinical experience as a Registered Nurse or a Licensed Practical Nurse (LPN). Clinical experience may include work in an acute care hospital, public health clinic, home health agency, or nursing facility. Documentation of both license and clinical experience must be maintained in the nurse's personnel file for review by DMAS staff. There must also be documentation of positive work history as evidenced by at least two satisfactory reference checks recorded in the nurse's personnel file.

The RN must provide supervision of personal/respite care aides. The RN supervisor must also offer quarterly in-service training, totaling a minimum of 12 hours within a calendar year. This in-service instruction may be provided by another qualified provider of such training, but the provider must offer in-service training that is appropriate in content and is offered to all staff providing personal care. The RN supervisor must offer in-service training (to include Medicaid requirements and policies and overall aide responsibilities) to all personal/respite care aides prior to their assignment to a Medicaid recipient and must document the offer in the aide's personnel file.

The RN supervisor must make an initial assessment visit prior to the start of care for any new patient admitted to personal/respite care. Each regularly assigned aide must be introduced to the assigned recipient by the RN supervisor or other staff (this may be done by telephone) and oriented to the recipient's plan of care on or prior to the aide's start of care for that recipient. The RN supervisor should closely monitor every situation when a new aide is assigned to a recipient so that any difficulties or questions are dealt with promptly.

The RN supervisor shall make supervisory visits as often as needed to ensure both quality and appropriateness of personal, respite, and, if applicable, the personal emergency response systems services. A minimum frequency of these visits is every 30 days, not monthly. The aide must be present during the RN supervisor's visit at least every other visit. If the aide is present during all supervisory visits, the RN supervisor should contact the recipient by telephone during non-personal care hours to assess the recipient's satisfaction with services. This telephone contact must be documented in the recipient's record. If the recipient is hospitalized on the day the 30-day RN supervisory visit is due, the RN supervisor's visit is due by the third calendar day after the resumption of personal care services following hospitalization. For example, a RN supervisory visit was made on January 1 with the next visit due no later

than January 31. The recipient is hospitalized from January 27 through February 5, and services resume February 6. The RN supervisory visit for the 30-day period (January 1 through January 31) had not occurred prior to the recipient's hospitalization. Therefore, a RN supervisory visit is due on or before February 9.

When split-shift service is provided, the RN supervisor must alternate the supervisory visit between both shifts in order to provide supervision to each aide. Also, if weekend or night service is provided (example: 11:00 P.M. until 7:00 A. M.), the RN supervisor must make a visit at least every other month during the time the aide is working.

When respite care services are not received on a regular basis, but are episodic in nature (e.g., respite care is offered for one full week during a six-month period), the RN supervisor is not required to conduct a supervisory visit every 30 days if the recipient is currently receiving personal care services. Instead, the RN supervisor must conduct the initial visit with the respite care aide immediately preceding the start of care and make a second home visit within the respite care period. If the recipient is not currently receiving personal care services, the RN supervisor must conduct the initial visit with the respite care aide immediately preceding the start of care and must conduct a supervisory visit every 30 days.

If the respite care is for a very short period of time (i.e., a weekend), the RN supervisor must conduct the initial visit with the respite care aide immediately preceding the start of care and make a telephone call to the aide during the period of respite care for the second visit. This telephone conversation must be clearly documented in the recipient's record. If the recipient is currently receiving personal care services, and they are going to continue during the respite care period, the RN supervisor does not have to make a second visit during the respite care period regardless of the length of the period. A follow-up telephone call to the primary caregiver should be made following the respite period.

In all cases, the RN supervisor must be available to the aide for conference pertaining to recipients being served by the aide. Ongoing assessment of the aide's performance by the RN supervisor is also expected to ensure the health, safety, and welfare of the recipient.

A RN supervisor must be available to the aides by telephone at all times that an aide is providing services to a recipient. A provider may contract with a RN supervisor to provide this service or find other means to meet this requirement since the provider cannot be without an RN supervisor. Any lapse in RN coverage must be reported immediately to the WVMI CBC Review Unit.

2. Personal/Respite Care Aide

Each aide hired by the provider must be evaluated by the provider to ensure

compliance with qualifications as required by DMAS. Basic qualifications for personal/respite care aides include:

- Physical ability to do the work;
- Ability to read and write;
- Completion of a 40-hour training program consistent with DMAS requirements. Prior to assigning an aide to a recipient, the provider must obtain documentation that the aide has satisfactorily completed a training program consistent with DMAS requirements. (See "Exhibits" at the end of this chapter for the Aide Training Course Outline.);

  DMAS requirements may be met in one of three ways:

  a. Registration as a Certified Nurse Aide: The Virginia Board of Nursing maintains a registry for Certified Nurse Aides. Each aide who is registered with the Board of Nursing will have a certificate of registration containing a registration number and an expiration date. Any aide who has such a certificate meets the DMAS standard for participation as a personal/respite care aide. A copy of the State certificate must be maintained in the aide's personnel record. If the certification has expired and the aide has not renewed the certification, the agency must contact the Board of Nursing to ensure that the aide's certification was not revoked for disciplinary reasons and that the aide meets one of the other two DMAS requirements. DMAS does not require a Board of Nursing Nurse Aide Certification to perform personal/respite care services; it is merely one type of certification which meets DMAS requirements.

  b. Graduation from an Approved Educational Curriculum: The Board of Nursing has an approved list of educational curricula offered by educational institutions throughout the Commonwealth of Virginia which offer certificates qualifying the student as a Nursing Assistant, Geriatric Assistant, or Home Health Aide. If an aide has successfully completed one of these Board of Nursing approved courses, the provider must obtain a copy of the applicant's certificate, ensure that it is from a Board of Nursing accredited institution, and maintain this documentation in the aide's personnel file for review by DMAS staff.

     Nursing Assistant training is also provided by numerous hospitals, nursing facilities, and educational institutions which are not Board of Nursing approved (e.g., out-of-state curricula). To ensure that the training content for a Nursing Assistant Program not approved by the Board of Nursing meets the minimum acceptable requirements, the agency must contact the DMAS Waiver Services Unit to determine whether the curriculum has previously been approved by DMAS. If

the curriculum was not previously approved by DMAS, the provider must obtain the curriculum and submit it to DMAS for approval prior to offering employment for Medicaid reimbursed cases.

c. Provider-Offered Training: In lieu of participating in a course offered at an educational institution, a provider may develop and offer his or her own training program. The content of the training must be consistent with the Aide Training Course Outline found in the Exhibits at the end of this chapter, must be a minimum of 40 hours, and must be approved by DMAS.

Regardless of the method of training received, documentation must be present indicating the training has been received prior to assigning an aide to a recipient. Based on continuing evaluations of the aide's performance and the recipient's individual needs, the nurse supervisor shall identify any significant gaps in the aide's ability to function competently and shall provide the necessary training.

The provider should verify information on the application form prior to hiring a personal/respite care aide. It is important that the minimum qualifications be met by each aide hired to ensure the health and safety of recipients. These qualifications must be documented and maintained in the provider personnel files for review by DMAS staff. In addition, the provider shall not hire any persons who have been convicted of barrier crimes as defined in § 32.1-162.9:1 of the Code of Virginia.

- Satisfactory work record verified through at least two references from prior employment. If possible, obtain references from the educational facility, vocational school, or institution where the aide's training was received. Documentation of the date of the reference check, the individual contacted and his or her relationship to the aide (friend, co-worker, supervisor), and the content of the reference must be maintained in the employee's record;

- Aide may be a non-family live-in caregiver for any competent recipient. In these situations, the registered nurse supervisor must have contact with the recipient monthly when the non-family live-in caregiver is not present; and

- A personal/respite care aide may not be parents of minor children, spouses, or legally responsible relatives. Payment will not be made for services provided by other family members unless there is objective written documentation as to why there are no other providers available. The family member providing care to the recipient must be employed by the personal/respite care provider, and meet the same requirements as other aides.

3. Licensed Practical Nurse

Through the respite care program, the provider may be reimbursed for the services of a licensed practical nurse currently licensed to practice in the Commonwealth as long as the provider can document the recipient's skilled needs. DMAS will reimburse for licensed practical nursing respite care only to those recipients who require the skilled level of care and who have no support system other than the primary caregiver, who is the recipient of respite care.

The circumstances that warrant provision of respite care by a licensed practical nurse are:

- The recipient receiving care has a need for routine skilled care which cannot be provided by unlicensed personnel (i.e., recipient on a ventilator, recipient requiring nasogastric or gastrostomy feedings, etc.);
- No other individual in the recipient's support system is able to provide the skilled component of the individual's care during the caregiver's absence.
- The recipient is unable to receive skilled nursing visits from any other source which could provide the skilled care usually given by the caregiver; and

The provider must verify a satisfactory work record verified through at least two references obtained from prior employment. References must be employment references from the applicant's supervisor, unless the individual has never worked, in which case the references must be from individuals not related to the applicant. Documentation of the date of the reference check, the individual contacted and the relationship to the nurse (friend, co-worker, supervisor), and the content of the reference must be maintained in the employee's record.

Documentation of all staff credentials must be maintained in the provider's personnel files for review by DMAS staff.

Inability to Provide Services and Substitution of Aides

The provider is responsible for providing reliable, continuous care to any Medicaid personal/respite care recipient for the number of hours and days outlined on the plan of care. DMAS considers a high degree of continuity to be no more than six days missed coverage in a one-month period. Any time the provider is unable to furnish an aide to perform services authorized in the plan of care, the recipient or recipient's family must be notified immediately and documentation of the contact recorded in the recipient's file. For personal care, when the permanent aide is absent, the provider must attempt to provide a substitute aide. An inability to provide service can be considered a serious threat to the safety and health of a recipient who does not have a support system available to provide back-up support.

The provider should explore with the recipient, prior to the start of services, his or her back-up plan or ability to go without service (in the event the provider cannot send a substitute aide). Back-up support can be provided by an informal network of friends or neighbors, or both, who can be called on as needed as long as this ensures the recipient's needs are met.

If a provider cannot supply an aide to provide authorized services, the provider can either obtain a substitute aide from another provider, or can transfer the recipient to another provider. If no other provider is available, and the recipient's health, safety, and welfare are in jeopardy, the provider must follow the procedure outlined in "Change in Services by the Personal/Respite/ADHC Provider-Advance Notice Not Required," in Chapter IV of this manual. The provider may update the UAI, and attach a narrative about the recipient's level of functioning, any pertinent changes, why facility placement is being sought, and if a nursing facility bed is being held or if recipient is on a waiting list at a nursing facility. This documentation is to be submitted to the analyst on telephone duty for the Facility and Home Based Services (F&HBS) Unit at DMAS. It may be faxed to (804) 371-4986. The provider must inform the recipient that Medicaid eligibility could be affected if services are not received for 30 days. The provider must also inform the recipient that a new screening must be completed by the local Screening Team if services are not received for 180 days.

The recipient and caregiver should be offered the option of the recipient attending adult day health care if a substitute aide cannot be located. An adult day health care provider could provide meals during the attendance, socialization, supervision and personal care.

During temporary, short-term lapses in coverage (not to exceed two weeks in duration), a substitute aide may be secured from another provider or other home care agency. The following procedure applies:

- The provider having recipient responsibility must provide the Registered Nurse supervision for the substitute aide;

- The agency providing the substitute aide must send to the provider having recipient care responsibility a copy of the aide's daily records signed by the recipient and the substitute aide. All documentation of services rendered by the substitute aide must be in the recipient's record. The substitute aide must meet DMAS qualifications, and documentation of the substitute aide's qualifications must be obtained and recorded in the agency having recipient care responsibility; and

- The provider having recipient care responsibility will bill DMAS for services rendered by the substitute aide. (The two agencies involved are responsible for working out the financial arrangement of paying the substitute aide.)

Substitute aides obtained from other providers should be used only in cases where no other arrangements can be made for personal care services coverage, and should be used on a temporary basis. If a substitute aide is needed for more than two weeks, the case must be transferred to another provider that has the aide capability to serve the recipient(s).

If an agency secures a substitute aide, it is the responsibility of the provider having recipient care responsibility to ensure that all DMAS requirements continue to be met, including documentation of the services rendered by the substitute aide and documentation that the substitute aide's qualifications meet DMAS requirements.

Some recipients take turns staying with different relatives throughout the year in different parts of the state. Rather than transferring a case back and forth, one primary provider (which could be an ADHC or a personal/respite care provider) may contract with a provider in another city or county to provide services. In that event, the same procedure should be followed for obtaining a substitute aide.

Business Office

The provider must operate from a business office which is staffed and provides accessible staff space, files, business telephones, and an address for receipt of mail and forms.

Change of Ownership

When ownership of the provider changes, DMAS and First Health must be notified immediately, but no later than 15 calendar days, from the effective date of the change. A new participation agreement with a notice of organizational structure, statements of financial solvency and service comparability, and full disclosure of all information required by this chapter relating to ownership and interest will be required.

In addition to the above, all personal/respite care providers enrolled in the Virginia Medicaid Program must adhere to the conditions outlined in their individual participation agreements.

PROVIDER PARTICIPATION STANDARDS FOR ADULT DAY HEALTH CARE SERVICES

Licensing Requirement

To be enrolled as a Medicaid Adult Day Health Care provider, the Center must be an Adult Day Care Center licensed by the Virginia Department of Social Services (DSS). A copy of the current license must be available to First Health for verification purposes prior to enrollment as a Medicaid provider. DMAS will notify DSS when an Adult Day Health Care agreement is made with a Center. DSS will notify DMAS whenever a change to the Center's status as a licensed Adult Day Care Center is made by DSS.

Each ADHC Center participating with Medicaid is responsible for adhering to the DSS Adult Day Care Center standards. The DMAS special participation conditions included here are standards imposed in addition to DSS standards, which must be met to perform Medicaid ADHC services.

Physical Plant Requirements

The Center must be able to provide a separate room or area, equipped with one bed or cot for every six Medicaid ADHC recipients. This bed or cot must be available for anyone who becomes ill, needs to rest, or needs to have privacy.

Staff Requirements

The number of staff required for an ADHC Center depends upon the level of care required by its participants. Each ADHC Center is required to employ sufficient interdisciplinary staff to adequately meet the health, maintenance, and safety needs of each recipient. The following staffing guidelines are required by DMAS. However, DMAS reserves the right to require an ADHC Center to employ additional staff, if, on review, DMAS staff find evidence of unmet recipient needs.

"Staff" when used to define requirements, includes professional and aide staff.

"Professional staff" will be used to indicate the Director, Activities Director, Registered Nurse, or Therapist.

Adult Day Health Care Minimum Staffing Requirements

1. The ADHC Center will always maintain a minimum staff-recipient ratio of one staff member to every six recipients (Medicaid and other participants).

2. There shall be at least two (2) staff persons at the Center at all times when there are Medicaid recipients in attendance.

3. In the absence of the Director, a professional staff member shall be designated to supervise the program.

4. Volunteers shall be included in the staff-recipient ratio only when they meet the qualifications and training requirements as paid staff and for each volunteer, there shall be at least one paid employee also included in the staff-recipient ratio.

5. Any Center that is co-located with another facility shall count only its own separate identifiable staff in the Center's staff-recipient ratio.

6. The Adult Day Health Care Center must employ staff sufficient to meet the needs of the recipients. These staff are the:

    - Director - responsible for the overall management of the Center's programs. This individual is the provider contact person for WVMI and is responsible for participation agreements and receiving and responding to communication from DMAS. The Director is responsible for ensuring

the initial development of the Plan of Care (DMAS-301) for ADHC recipients;

- Activities Director - responsible for directing recreational and social activities for the ADHC recipients;

- Program Aides - responsible for overall assistance with care and maintenance of the recipient (assistance with activities of daily living, recreational activities, and other health and therapeutic related activities); and

- Registered Nurse - responsible for administering and monitoring the health needs of the ADHC recipients. The nurse is responsible for the planning, organization, and management of a plan of care involving multiple services where specialized health care knowledge must be applied in order to attain the desired result. The nurse must be present a minimum of one full day (8 hours) each month at the Adult Day Health Care Center to render direct services to Medicaid ADHC recipients. The nurse must be available to meet the nursing needs of all Medicaid ADHC recipients; however, DMAS does not require that the nurse be a full-time staff position. There must be a nurse available, by telephone at a minimum, to the Center's recipients during all times the Center is in operation. The ADHC Center may contract with either an individual or agency to provide these services, but the ADHC Center must ensure quality service delivery and coordination of the plan of care.

  The ADHC Center may use one person to fill more than one professional position as long as the requirements for both positions and other staffing requirements are met. The Center may employ staff as either full-time or part-time as long as the person hired can fulfill the duties of the position and meet the needs of the recipients. DMAS will enter into participation agreements only with Centers employing a sufficient number of staff whose employment status (full-time, part-time, or contracted RN services) is determined to be sufficient based on the number of recipients in the Center and the overall functional level or specialized needs of those recipients.

7. The Director will assign a professional staff member to act as ADHC Coordinator for each recipient. The identity of the ADHC Coordinator must be documented in the recipient's file. The ADHC Coordinator is responsible for management of the recipient's plan of care and review of the recipient's plan of care with the program aides. In cases where the recipient only receives ADHC and PERS, the ADHC Coordinator is responsible for ensuring the continued appropriateness of PERS.

It is the ADHC Coordinator's responsibility to inform the program aides of changes in the plan of care and give instruction and direct supervision in any new tasks. If the recipient's plan of care requires a particular task a program aide is not familiar with, any professional

staff available is expected to provide the aide with instruction and direct supervision in the task.

Each professional staff member is responsible for providing input to the plan of care, sharing expertise with other staff members through in-services, providing direct supervision to aides or providing direct care to the recipients, or both.

A multi-disciplinary approach to problem identification, recipient goal setting, development and implementation of the plan of care, and supervision of nonprofessional staff is essential to ensure the provision of quality ADHC services. However, the Center Director has the ultimate responsibility for directing the Center program and supervision of its staff.

Minimum Qualifications of Adult Day Health Care Staff

I. Program Aide

Each program aide hired by the provider must be evaluated by the provider to ensure compliance with minimum qualifications as required by DMAS. The aide must, at a minimum, have the following qualifications:

- ability to read and write;
- physically able to do the work; and
- special training in the needs of elderly and disabled, through the completion of a minimum 40-hour training program consistent with DMAS requirements. The provider must obtain documentation that the aide has satisfactorily completed a training program consistent with DMAS requirements. (See "Exhibits" at the end of this chapter for the Adult Day Health Care Program Aide Training Outline.) DMAS requirements may be met in one of five ways:

1. Registration as a Certified Nurse Aide: The Virginia Board of Nursing maintains a registry for Certified Nurse Aides. Each aide who is registered with the Board of Nursing will have a certificate of registration, which contains a registration number and an expiration date. Any aide who has such a certificate meets the DMAS standard for participation as an Adult Day Health Care Aide. A copy of the state certification must be maintained in the aide's personnel record. If the certification has expired and the aide has not renewed the certification, the provider must contact the Board of Nursing to ensure that the aide's certification was not revoked for disciplinary reasons. DMAS does not require Board of Nursing Nurse Aide Certification in order to perform ADHC aide services; it is merely one type of certification that meets DMAS requirements.

2. Graduation from an Approved Educational Curriculum: The Board of Nursing has an approved list of educational curricula offered by

educational institutions throughout the Commonwealth of Virginia which awards certificates qualifying the graduate as a Nursing Assistant, Geriatric Assistant, or Home Health Aide. If an aide has successfully completed one of the Board of Nursing approved courses, the provider must obtain a copy of the applicant's certificate, verify that it is from a Board of Nursing accredited institution, and maintain the documentation in the aide's personnel file for review by DMAS staff.

Nursing Assistant training is also provided by numerous hospitals, nursing facilities, and educational institutions, which are not approved by the Board of Nursing (e.g. out-of-state curricula). To ensure that the training content for a Nursing Assistant Program not approved by the Board of Nursing meets the minimum acceptable requirements, the agency must contact the DMAS Waiver Services Unit to determine whether the curriculum has previously been approved by DMAS. If the curriculum was not previously approved by DMAS, the provider must obtain the curriculum and submit it to DMAS for approval prior to offering employment for Medicaid reimbursed cases.

3. Provider-Offered Training: In lieu of participation in a course offered at an educational institution, a provider may develop and offer his or her own training program. The content of the training must be consistent with the Adult Day Health Care Program Aide Training Outline found in the Exhibits at the end of this chapter, must be a minimum of 40 hours, and must be approved by DMAS.

4. Completion of the VADSA (Virginia Adult Day Services Association) aide training program is acceptable. This program has been previously reviewed and approved by DMAS. Note: an aide who has completed the VADSA training does not meet the qualifications as an aide for in-home personal/respite care services.

5. Completion of the most current National Adult Day Services Association curriculum. (Information for this curriculum can be accessed by mailing a request in writing to the address below or by contacting their web site at www.ncoa.org/nadsa/nadsa-products.htm):

   The National Adult Day Health Services Association
   409 Third St., SW
   Suite 200
   Washington, DC 20024

   Note: An aide who has completed this training does not meet the qualifications as an aide for in-home personal/respite care services.

- Satisfactory Work Record Including No Evidence of Possible Abuse or Neglect of Incompetent or Incapacitated Individuals, or Both: The work record must be verified through at least two references obtained prior to

employment. The references must be employment references from the applicant's supervisor, unless the individual has never worked, in which case the references must be from individuals not related to the applicant. Documentation of the date of the reference check, the individual contacted, his or her relationship to the aide (friend, co-worker, and supervisor), and the content of the reference must be maintained in the employee's record.

Regardless of the method of training received, documentation must be present indicating the training has been received prior to assigning an aide to ADHC recipients. The provider must verify information on the application form prior to hiring an ADHC program aide. It is important that the minimum qualifications be met by each hired aide to ensure the health and safety of recipients.

II. Registered Nurse

The Registered Nurse must:

A. be registered and currently licensed to practice nursing in the Commonwealth of Virginia;

B. have two years of related clinical experience as a Registered Nurse. Clinical experience may include work in an acute care hospital, rehabilitation hospital, public health clinic, home health agency or nursing facility;

C. have a satisfactory work record including no evidence of abuse or neglect of incompetent or incapacitated individuals, or both, and documentation of positive work history as evidenced by at least two reference checks recorded in the nurse's personnel file. Documentation of both license and clinical experience must be maintained in the provider's personnel file for review by DMAS staff. A copy of the nurse's current license must be in the personnel record.

III. Activity Director

The Activity Director must:

A. have a minimum of 48 semester hours or 72 quarter hours of post secondary education from an accredited college or university with a degree in recreational therapy, occupational therapy, or a related field such as art, music, or physical education;

B. have one year of related experience which may include work in an acute care hospital, rehabilitation hospital, nursing home, or have completed a course of study including the prescribed internship in occupational, physical, and recreational therapy or music, dance, art therapy, or physical education; and

C. have a satisfactory work record as evidenced by references from prior job experience, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults and children.

IV. Director

The Director must meet the qualifications of the Director as specified in the DSS standards for Adult Day Care Centers.

Documentation of all staff credentials must be maintained in the provider's personnel files for review by DMAS staff.

Re-Evaluation of the Adult Day Health Care Recipient

The ADHC center professional staff will continually assess the adequacy of ADHC services for each recipient and shall meet and document changes in the recipient's condition and plan of care at least every three months.

Whenever the professional staff determines that ADHC services, either alone or in combination with other community resources, are no longer appropriate for a recipient, the Center will contact a review analyst at WVMI. The review analyst will conduct a re-evaluation of the recipient's needs to ensure that the recipient is receiving services which meet his or her needs and ensure the recipient's continued health and safety in the community in a cost-effective health care setting.

DMAS will conduct annual level of care reviews of each recipient according to established procedures described in Chapter VI.

Inability to Provide ADHC Services

The provider is responsible for providing reliable, continuous care to any Medicaid adult day health care recipient for the number of hours per day or days per week as outlined on the plan of care. Any time the provider is unable to furnish ADHC services as determined in the plan of care, the recipient or recipient’s family must be notified immediately, and documentation of the contact recorded in the recipient file. An ADHC provider may sub-contract with another ADHC provider if they cannot provide the number of days per week as written in the plan of care.

The provider should explore with the recipient, prior to the start of services, his or her back-up plan or ability to go without service (in the event the provider cannot provide ADHC services). Back-up support can be provided by an informal network of friends or neighbors who can be called on as needed as long as this ensures the recipient’s needs are met.

In addition to the above, all ADHC providers enrolled in the Virginia Medicaid Program must adhere to the conditions outlined in their individual participation agreements.

PROVIDER PARTICIPATION STANDARDS FOR PERSONAL EMERGENCY RESPONSE SYSTEMS

In addition to meeting the general conditions and requirements for home and community-based care participating providers, PERS providers must also meet the following qualifications.

To be enrolled as a provider of personal emergency response systems (PERS), a provider must be a certified home health or personal care agency, a durable medical equipment provider, a hospital, or a PERS manufacturer that has the ability to provide PERS equipment, direct services (i.e., installation, equipment maintenance and service calls), and PERS monitoring. All PERS providers must enroll as durable medical equipment provider in order to provide this service to Medicaid recipients and to receive reimbursement from Medicaid. Enrollment as a DME provider does not obligate the PERS provider to provide any other DME services.

The PERS provider must provide an emergency response center staff with fully trained operators who are capable of receiving signals for help from a recipient's PERS equipment 24-hours a day, 365, or 366 as appropriate, days per year; determining whether an emergency exists; and notifying an emergency response organization or an emergency responder that the PERS recipient needs emergency help.

The PERS provider must comply with all applicable Virginia statutes and all applicable regulations of DMAS and all other governmental agencies having jurisdiction over the services to be performed.

The PERS provider has the primary responsibility to furnish, install, maintain, test, and service the PERS equipment, as required to keep it fully operational. The provider shall replace or repair the PERS device within 24-hours of the recipient's notification of a malfunction of the console unit or activating devices, while the original equipment is being repaired.

The PERS provider must properly install all PERS equipment into a PERS recipient's functioning telephone line and must furnish all supplies necessary to ensure that the system is installed and working properly.

The PERS installation includes local seize line circuitry, which guarantees that the unit will have priority over the telephone connected to the console unit should the telephone be off the hook or in use when the unit is activated.

The PERS provider must maintain all installed PERS equipment in proper working order.

The PERS provider must maintain a data record for each PERS recipient at no additional cost to DMAS. The record must document all of the following: delivery date and installation date of the PERS; enrollee/caregiver signature verifying receipt of the PERS device; verification by a test that the PERS device is operational, monthly or more frequently as needed; updated and current recipient responder and contact information, as

provided by the recipient or the recipient's care provider; and a case log documenting recipient system utilization and recipient or responder contacts and communications.

The PERS provider must have back-up monitoring capacity in case the primary system cannot handle incoming emergency signals.

All PERS equipment must be approved by the Federal Communications Commission and meet the Underwriters' Laboratories, Inc. (UL) safety standard Number 1635 for Digital Alarm Communicator System Units and Number 1637, which is the UL safety standard for home health care signaling equipment. The UL listing mark on the equipment will be accepted as evidence of the equipment's compliance with such standard. The PERS device must be automatically reset by the response center after each activation, ensuring that subsequent signals can be transmitted without requiring manual reset by the recipient.

The PERS provider must furnish education, data, and ongoing assistance to DMAS to familiarize staff with the service, allow for ongoing evaluation and refinement of the program, and must instruct the recipient, caregiver, and responders in the use of the PERS service.

The emergency response activator must be activated either by breath, by touch, or by some other means, and must be usable by persons who are visually or hearing impaired or physically disabled. The emergency response communicator must be capable of operating without external power during a power failure at the recipient's home for a minimum period of 24-hours and automatically transmit a low battery alert signal to the response center if the back-up battery is low. The emergency response console unit must also be able to self-disconnect and redial the back-up monitoring site without the recipient resetting the system in the event it cannot get its signal accepted at the response center.

Monitoring agencies must be capable of continuously monitoring and responding to emergencies under all conditions, including power failures and mechanical malfunctions. It is the PERS provider's responsibility to ensure that the monitoring agency and the agency's equipment meets the following requirements. The monitoring agency must be capable of simultaneously responding to multiple signals for help from the recipient's PERS equipment. The monitoring agency's equipment must include the following: a primary receiver and a back-up receiver, which must be independent and interchangeable; a back-up information retrieval system; a clock printer, which must print out the time and date of the emergency signal, the PERS recipient's identification code, and the emergency code that indicates whether the signal is active, passive, or a responder test; a back-up power supply; a separate telephone service; a toll-free number to be used by the PERS equipment in order to contact the primary or back-up response center; and a telephone line monitor, which must give visual and audible signals when the incoming telephone line is disconnected for more than 10 seconds.

The monitoring agency must maintain detailed technical and operation manuals that describe PERS elements, including the installation, functioning, and testing of PERS equipment; emergency response protocols; and record keeping and reporting procedures.

The PERS provider shall document and furnish a written report for each emergency signal that results in action being taken on behalf of the recipient. This excludes test signals or activations made in error. This written report shall be furnished to the personal care provider, or in cases where the recipient only receives ADHC services, to the ADHC provider.

The PERS provider is prohibited from performing all types of direct marketing activities to Medicaid recipients. "Direct marketing" means directly or indirectly conducting door-to-door, telephonic, or other "cold call" marketing of services at residences and provider sites; mailing directly; paying "finders fees"; offering financial incentives, rewards, gifts or special opportunities to eligible recipients as inducements to use their services; continuous, periodic marketing activities to the same prospective recipient, e.g., monthly, quarterly, or annual give-aways, as inducements to use their services; or engaging in marketing activities that offer potential customer rebates or discounts in conjunction with the use of their services or other benefits as a means of influencing recipients' use of providers' services.

In addition to the above, all PERS providers enrolled in the Virginia Medicaid Program must adhere to the conditions outlined in their individual participation agreements.

RECIPIENT CHOICE OF PROVIDER

If services are authorized and there is more than one approved provider in the community, the recipient will have the option of selecting the provider of his or her choice.

UTILIZATION REVIEW

Utilization review is conducted periodically. DMAS utilization review analysts will review provider compliance with participation standards during utilization review. DMAS may retract funds based on documentation reviewed. (See Chapter VI for more information about utilization review.)

ADVANCE DIRECTIVES

At the time of admission to Elderly and Disabled Waiver services, all providers participating in the Medicare and Medicaid programs must provide adult recipients with written information regarding a recipient's right to make medical care decisions as outlined in this section. This includes the right to accept or refuse medical treatment and the right to formulate advance directives.

The term "advance directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law and relating to the provision of such care when the individual is incapacitated. The law does not prohibit any health care provider (or any agent of such provider) from refusing, as a matter of conscience, to implement an advance directive. Further, the law does not require individuals to execute an advance directive.

Under the law, providers must:

- provide all adult individuals with written information about their rights under Virginia law to make health care decisions, including the right to accept or refuse treatment and the right to execute advance directives as well as the provider's written policies respecting the implementation of such rights;

- inform recipients about the provider's policy on implementing advance directives;

- document in the medical record whether he or she has signed an advance directive;

- not discriminate against an individual based on whether he or she has executed an advance directive; and

- provide staff and consumer education on advance directives.

RECIPIENT RIGHTS/RESPONSIBILITIES

The provider must have a written statement of recipient rights which clearly states the responsibilities of both the provider and the recipient in the provision of care. This statement of recipient rights must be signed by the recipient and the provider representative at the time services are initiated. This statement must be maintained in the recipient's file, and a copy must be given to the recipient. The statement of recipient rights must include the following:

- the provider's responsibility to notify the recipient in writing of any action taken which affects the recipient's services;

- the provider's responsibility to render services according to acceptable standards of care;

- the provider's procedures for patient pay collection;

- the recipient's obligation for patient pay, if applicable;

- the provider's responsibility to make a good faith effort to provide care according to the scheduled plan of care and to notify the recipient when unable to provide care;

- the provider must inform the recipient of his or her responsibility to have some planned back-up for times when the provider is unable to secure coverage and to identify which staff the recipient should contact regarding schedule changes;

- the provider's responsibility to treat the recipient with respect, to respond to any questions or concerns about the care rendered, and to routinely check with the recipient about his or her satisfaction with the services being rendered;

- the recipient's responsibility to notify the appropriate provider staff whenever the recipient's schedule changes or assigned staff fail to appear for work; and

- the recipient's responsibility to treat provider staff with respect and to communicate problems immediately to the appropriate provider staff.

The Recipient's Rights/Responsibilities Statement must include the following notification of the appropriate resources for complaint resolution:

"The DMAS (Medicaid) pays (provider name) to provide (type of service) to you. If you have a problem with these services you should contact (RN, ADHC Coordinator, Provider Director, or PERS provider) at (provider telephone).

If the staff at the agency is unable or unwilling to help you resolve the problem, you may contact WVMI, the DMAS contractor, in writing or by telephone at:

WVMI
Attn: CBC Review
Bank of America Bldg., Suite 402
1111 E. Main Street
Richmond, Virginia 23219
(804) 648-3159 - Richmond
1-800-299-9864 – All other areas

REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT

Section 504 provides that no otherwise qualified individual with a disability shall, solely by reason of his or her disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Act requires reasonable accommodations for certain persons with disabilities.

In the event a discrimination complaint is lodged, DMAS is required to provide the federal Office of Civil Rights (OCR) with any evidence regarding compliance with these requirements.

TERMINATION OF PROVIDER PARTICIPATION

The participation agreement is not time-limited. It will only expire upon the lapse or loss of licensure or certification of the provider, action taken by DMAS to meet the requirements of the agreement, regulations or law, inactive participation by the provider (no billing within 36 months), or resignation by the provider. DMAS will request a copy of the renewed license or certification prior to its expiration.

A participating provider may terminate participation in Medicaid at any time; however, written notification must be provided to the DMAS Director and to the First Health Provider Enrollment Unit thirty (30) days prior to the effective date. The addresses are as follows:

Director
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

First Health VMAP Provider Enrollment Unit
P.O. Box 26803
Richmond, Virginia 23261

DMAS may terminate a provider from participating upon 30 days' written notification prior to the effective date. Such action precludes further payment by DMAS for services provided to recipients after the date specified in the termination notice.

TERMINATION OF A PROVIDER CONTRACT UPON CONVICTION OF A FELONY

Subsection (c) of § 32.1-325 of the Code of Virginia mandates that "Any such [Medicaid] agreement or contract shall terminate upon conviction of the provider of a felony." A provider convicted of a felony in Virginia or in any other of the 50 states must, within 30 days, notify DMAS of this conviction and relinquish the agreement. Reinstatement will be contingent upon provisions of state law.

RECONSIDERATION AND APPEALS OF ADVERSE ACTIONS

The following procedures will be available to all providers when DMAS takes adverse action.

The reconsideration and appeals process will consist of three phases: a written response and reconsideration to the preliminary findings, an informal conference, and a formal evidentiary hearing. The provider will have 30 days from the date of the notice to submit information for written reconsideration, 30 days to request an informal conference and 30 days to request a formal evidentiary hearing.

An appeal of adverse actions concerning provider reimbursement shall be heard in accordance with the Administrative Process Act (§§ 9-6.14:1 through 2.2-4000 et seq. of the Code of Virginia) and the *State Plan for Medical Assistance* provided for in § 32.1 – 325 of the Code of Virginia. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the Administrative Process Act.

Any legal representative of a provider must be duly licensed to practice in the Commonwealth of Virginia.

MEDICAID PROGRAM INFORMATION

Federal regulations governing program operations require Virginia Medicaid to supply program information to all providers. The current system of distributing this information is keyed to the provider number on the enrollment file, which means that each assigned provider receives program information.

A provider may not wish to receive provider manuals or Medicaid memoranda because he or she has access to the publications as a part of a group practice. To suppress the receipt of this information, the First Health Provider Enrollment Unit (FH-PEU) requires the provider to complete the Mail Suppression Form (See "Exhibits" at the end of this chapter) and return it to:

First Health Provider Enrollment Unit
P.O. Box 26803
Richmond, Virginia 23261-6803

Upon receipt of the completed form, FH-PEU will process it and the provider named on the form will no longer receive publications from DMAS. To resume the mailings, a written request sent to the above address is required.

EXHIBITS

COMMONWEALTH OF VIRGINIA
Department of Medical Assistance Services
Medical Assistance Program

Home and Community Based Care Services Participation Agreement
Personal Care

If re-enrolling, enter Medicaid Provider Number here→ _____ Check this box if requesting new number→ ☐

This is to certify: **PAYMENT/CORRESPONDENCE ADDRESS** **PHYSICAL ADDRESS (*REQUIRED IF DIFFERENT FROM PAYMENT ADDRESS*)**

NAME

ATTENTION

ADDR LINE 1

ADDR LINE 2

CITY, STATE, ZIP

on this _____ day of _____, _____ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration of Medicaid.

1. **The provider agrees to provide services in accordance with the Provider Participation Standards published periodically by DMAS in the appropriate Provider Manual(s), after being fully certified by DMAS to provide such services. In addition, the provider agrees that all individuals providing services under this Agreement meet the criteria set forth in the above referenced Provider Manual(s).**
2. **Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. In accordance with the terms of Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794) no handicapped individual shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in DMAS.**
3. **The provider agrees to keep such records as DMAS determines necessary. The provider will furnish DMAS on request information regarding payments claimed for providing services under the State Plan. Access to records and facilities by authorized DMAS representatives and the Attorney General of Virginia or his authorized representatives, and authorized federal personnel will be permitted upon reasonable request.**
4. **The provider agrees that charges submitted for services rendered will be based on the usual, customary, and reasonable concept and agrees that all requests for payment will comply in all respects with the policies of VMAP for the submission of claims.**
5. **Payment made under DMAS constitutes full payment on behalf of the recipient except for patient pay amounts determined by DMAS, and the provider agrees not to submit additional charges to the recipient for services covered under DMAS. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a DMAS recipient for any service provided under DMAS is expressly prohibited and may subject the provider to federal or state prosecution.**
6. **The provider agrees to pursue all other health care resources of payment prior to submitting a claim to DMAS.**
7. **Payment by DMAS at its established rates for the services involved shall constitute full payment for the services rendered. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by DMAS, the provider shall reimburse DMAS upon demand.**
8. **The provider agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of DMAS as from time to time amended.**
9. **This agreement may be terminated at will on thirty days' written notice by either party or by DMAS when the provider is no longer eligible to participate in the Program.**
10. **All disputes regarding provider reimbursement and/or termination of this agreement by DMAS for any reason shall be resolved through administrative proceedings conducted at the office of DMAS in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.**
11. **The provider agrees, at all times, to retain full responsibility for any and all performance under this agreement, whether performed by the provider or others under contract to the provider.**

12. **This agreement shall commence on _____. Your continued participation in the Virginia Medicaid Program is contingent upon the timely renewal of your license. Failure to renew your license through your licensing authority shall result in the termination of your Medicaid Participation Agreement.**

For Provider of Services:

For First Health Services' use *only*

Director, Division of Program Operations Date

Original Signature of Provider Date

Title

_____City or _____County of _____

IRS Identification Name (required)

IRS Identification Number (Area Code) Telephone Number

Mail or fax **one** completed **original** agreement to:
First Health - VMAP-Provider Enrollment Unit
PO Box 26803
Richmond, Virginia 23261-6803
1-804-270-7027

Medicare Carrier and Vendor Number

HOME AND COMMUNITY-BASED CARE APPLICATION FOR PROVIDER STATUS AS A PERSONAL CARE PROVIDER

Name your agency will do business as: _____

PART A. PREVIOUS PROVIDER EXPERIENCE

1. Type of Related Experience:

I request to be approved as a provider of Personal Care services.
My agency is currently a Virginia Medicaid-enrolled provider of Home Health, Hospital, Rehab, Hospice, Nursing Facility, Clinic or one of the Community-Based Care services.

Yes ☐ No ☐

Type of Provider _____ Provider ID # _____

Type of Provider _____ Provider ID # _____

Type of Provider _____ Provider ID # _____

2. Please type or print the Administrator's Name:

_____

PART B. GENERAL INFORMATION

In accordance with Federal requirements, all providers of Home and Community-Based Care services must submit the following information to the Department of Medical Assistance Services. The information you provide in this section will help us identify information you send to us, and direct where we send critical information you will need as a provider. Please be sure you follow the directions and accurately note the information requested so that we can provide you with quality service.

ADMINISTRATIVE PERSONNEL ***(Fill in all that apply.)***

_____ _____ _____

Person responsible for signing contract Title Phone number

This person is responsible for general management of requested Medicaid program(s)

Reports to:_____

_____ _____ _____

Chief Administrator On-site Title Phone number

This person is responsible for general management of requested Medicaid program(s)

Reports to:_____

_____ _____ _____

Other On-site Contact Person Title Phone number

This person is responsible for general management of requested Medicaid program(s)

Reports to:_____

_____ _____ _____

Chief Corporate Officer Title Phone number

_____ _____ _____

Other Corporate Contact Person Title Phone number

GEOGRAPHICAL AREAS TO BE SERVED (*See Chapter II for policy re: allowable service area)*

List Cities/Counties in which you intend to serve Medicaid-eligible recipients.

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

OWNERSHIP (FILL IN COMPLETELY FOR ALL OWNERS. INCLUDE PERCENT OF OWNERSHIP OF EACH) For Non-Profit Entities Section 501(c) (3), list the board members.

LEGAL NAME	ADDRESS	%
_____	_____	_____
_____	_____	_____
_____	_____	_____

OWNER(S) PARTICIPATION IN OTHER FEDERALLY FUNDED PROGRAMS

Federal requirements stipulate that any person listed above in with 5 percent or more ownership of any other Medicaid provider or agency that participates in any of the programs established under Title V, XVII, or XX of the Social Security Act must disclose such ownership.

CHECK ONE: _____ N/A _____ APPLICABLE, COMPLETE THIS SECTION

NAME	AGENCY NAME	TYPE OF BUSINESS
_____	_____	_____
_____	_____	_____
_____	_____	_____

TYPE OF AGENCY (PLEASE CHECK ALL THAT APPLY)

Non-Profit	Proprietary	State or Local Government
____ Church Related	____ Single Proprietorship	____ State
____ Non-Profit Corporation	____ Partnership	____ County/City
____ Other Non-Profit Ownership	____ Corporation	____ Hospital (District Authority)
	____ Hospital/Nursing Facility	

CHECK ANY OF THE FOLLOWING SERVICES YOUR AGENCY PROVIDES:

Durable Medical Equipment Home Health Social Work Services Hospice
Rehabilitation Services Case Management Others _____

REQUIREMENTS AND SIGNATURE

Any changes which affect the accuracy of the information on this application must be reported promptly to the Community-Based Care Section of the Department of Medical Assistance Services.

Federal requirements stipulate that upon each submission of the provider agreement (or upon actual notice to the provider, whichever is sooner) disclosure of the identity of any person (not limited to but including any owner, operator, manager and/or employee) associated with the agency who has been convicted of a criminal offense (misdemeanor and/or felony) must be made. It is the duty of the provider to make inquiry and screen individuals at the point of application for employment to comply with this section.
Has anyone associated with the agency (owner, operators, managers or employees) been convicted of a criminal offense? **Yes** **No** .
If yes, explain the type of offense, and title of individual:_____

_____

The signature below certifies the following:

- That the chief administrative agent understands that in order to comply with Federal regulations, it will not charge DMAS a higher rate for Home and Community-Based Care Services than is charged the private sector for the same services

- That there is neither a judgment nor pending action of insolvency or bankruptcy in a State or Federal Court and that the provider of services agrees to inform the Department of Medical Assistance Services (DMAS) immediately if court proceedings to make a judgment of insolvency or bankruptcy are instituted with respect to the provider of services.

- That the chief administrative agent and professional staff have received and reviewed the program description materials of the Home and Community-Based Care services prior to completing this application.

- That the information within this application is accurate, truthful, and complete.

- That DMAS is authorized to make any contact or inquiries necessary to facilitate completion of the application process.

_____ _____
Print Name of person signing application Print title

_____ _____
Signature of person signing contract Date

PART C. CBC PROGRAM STAFF CREDENTIALS AND REQUIREMENTS

COMPLETE FOR PERSONAL CARE

You are responsible for assuring that RN supervisory and aide staff meet the qualifications detailed in chapter II of the provider manual. All RN's who perform supervisory activities for the personal care program are expected to be knowledgeable of the personal care criteria, definitions for the completion of the functional status assessment and all program requirements, regardless of whether they perform these activities on a part time basis. It is the provider's responsibility to assure that any new RN staff who provide RN supervision for the personal care program are oriented to the program and have the policy, procedures and forms necessary to comply with DMAS requirements. The provider is responsible for instructing all aides who provide personal care in the program requirements related to their performance of duties.

1. **List below the person who will be responsible for daily management of the Personal Care program and who they report to:**

_____ _____ _____
Name Title Phone Number
Reports to: _____ _____
Phone Number

_____ _____ _____
Name Title Phone Number
Reports to: _____ _____
Phone Number

2. **Indicate the number of staff, both full time (FT) and part time (PT) you currently have hired to provide Personal Care.**

# FT	# PT		# FT	# PT	
___	___	**Registered Nurses**	___	___	**Personal Care Aides**

3. **Complete the following for each RN who will provide supervision, on either a full time or part time basis. In the FT/PT column, indicate the percent of time the RN will devote to the Personal Care program.**

Name	FT/PT	License #	Expiration Date	Amount/Type Clinical Experience

Commonwealth Of Virginia
Department of Medical Assistance Services
Medical Assistance Program

Home and Community Based Care Services Participation Agreement
Adult Day Health Care

If re-enrolling, enter Medicaid Provider Number here→ _____ Check this box if requesting new number→ ☐

This is to certify:

PAYMENT/CORRESPONDENCE ADDRESS

NAME

ATTENTION

ADDR LINE 1

ADDR LINE 2

CITY, STATE, ZIP

PHYSICAL ADDRESS
(*REQUIRED IF DIFFERENT FROM PAYMENT ADDRESS*)

on this _____ day of _____, _____ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration of Medicaid.

1. **The provider agrees to provide services in accordance with the Provider Participation Standards published periodically by DMAS in the appropriate Provider Manual(s), after being fully certified by DMAS to provide such services. In addition, the provider agrees that all individuals providing services under this Agreement meet the criteria set forth in the above referenced Provider Manual(s).**
2. **Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. In accordance with the terms of Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794) no handicapped individual shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in DMAS.**
3. **The provider agrees to keep such records as DMAS determines necessary. The provider will furnish DMAS on request information regarding payments claimed for providing services under the State Plan. Access to records and facilities by authorized DMAS representatives and the Attorney General of Virginia or his authorized representatives, and authorized federal personnel will be permitted upon reasonable request.**
4. **The provider agrees that charges submitted for services rendered will be based on the usual, customary, and reasonable concept and agrees that all requests will comply in all respects with the policies of VMAP for the submission of claims.**
5. **Payment made under DMAS constitutes full payment on behalf of the recipient except for patient pay amounts determined by DMAS, and the provider agrees not to submit additional charges to the recipient for services covered under DMAS. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a DMAS recipient for any service provided under DMAS is expressly prohibited and may subject the provider to federal or state prosecution.**
6. **The provider agrees to pursue all other health care resources of payment prior to submitting a claim to DMAS.**
7. **Payment by DMAS at its established rates for the services involved shall constitute full payment for the services rendered. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by DMAS, the provider shall reimburse DMAS upon demand.**
8. **The provider agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of DMAS as from time to time amended.**
9. **This agreement may be terminated at will on thirty days' written notice by either party or by DMAS when the provider is no longer eligible to participate in the Program.**
10. **All disputes regarding provider reimbursement and/or termination of this agreement by DMAS for any reason shall be resolved through administrative proceedings conducted at the office of DMAS in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.**
11. **The provider agrees, at all times, to retain full responsibility for any and all performance under this agreement, whether performed by the provider or others under contract to the provider.**
12. **This agreement shall commence on _____. Your continued participation in the Virginia Medicaid Program is contingent upon the timely renewal of your license. Failure to renew your license through your licensing authority shall result in the termination of your Medicaid Participation Agreement.**

For Provider of Services:

Original Signature of Provider — Date

Title

_____City or _____County of _____

IRS Identification Number — (Area Code) Telephone Number

Medicare Carrier and Vendor Number

For First Health Services' use *only*

Director, Division of Program Operations — Date

IRS Name (Required)

mail or fax **one** completed **original** agreement to:

First Health - VMAP-Provider Enrollment Unit
PO Box 26803
Richmond, Virginia 23261-6803
1-804-270-7027

HOME AND COMMUNITY-BASED CARE APPLICATION FOR PROVIDER STATUS AS A ADULT DAY HEALTH CARE PROVIDER

Name your agency will do business as: _____

PART A. PREVIOUS PROVIDER EXPERIENCE

2. Type of Related Experience:

I request to be approved as a provider of Adult Day Health Care services.
My agency is currently a Virginia Medicaid-enrolled provider of Home Health, Hospital, Rehab, Hospice, Nursing Facility, Clinic or one of the Community-Based Care services.

Yes ☐ No ☐

Type of Provider _____ Provider ID # _____

Type of Provider _____ Provider ID # _____

Type of Provider _____ Provider ID # _____

3. Please type or print the Administrator's Name:

_____

PART B. GENERAL INFORMATION

In accordance with Federal requirements, all providers of Home and Community-Based Care services must submit the following information to the Department of Medical Assistance Services. The information you provide in this section will help us identify information you send to us, and direct where we send critical information you will need as a provider. Please be sure you follow the directions and accurately note the information requested so that we can provide you with quality service.

ADMINISTRATIVE PERSONNEL ***(Fill in all that apply.)***

_____ _____ _____
Person responsible for signing contract Title Phone number

☐ This person is responsible for general management of requested Medicaid program(s)

Reports to:_____

_____ _____ _____
Chief Administrator On-site Title Phone number

☐ This person is responsible for general management of requested Medicaid program(s)

Reports to:_____

_____ _____ _____
Other On-site Contact Person Title Phone number

☐ This person is responsible for general management of requested Medicaid program(s)

Reports to:_____

_____ _____ _____
Chief Corporate Officer Title Phone number

_____ _____ _____
Other Corporate Contact Person Title Phone number

GEOGRAPHICAL AREAS TO BE SERVED (*See Chapter II for policy re: allowable service area)*

List Cities/Counties in which you intend to serve Medicaid-eligible recipients.

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

OWNERSHIP (FILL IN COMPLETELY FOR ALL OWNERS. INCLUDE PERCENT OF OWNERSHIP OF EACH) For Non-Profit Entities Section 501(c) (3), list the board members.

LEGAL NAME	ADDRESS	%
_____	_____	_____
_____	_____	_____
_____	_____	_____

OWNER(S) PARTICIPATION IN OTHER FEDERALLY FUNDED PROGRAMS

Federal requirements stipulate that any person listed above in with 5 percent or more ownership of any other Medicaid provider or agency that participates in any of the programs established under Title V, XVII, or XX of the Social Security Act must disclose such ownership.

CHECK ONE: _____ N/A _____ APPLICABLE, COMPLETE THIS SECTION

NAME	AGENCY NAME	TYPE OF BUSINESS
_____	_____	_____
_____	_____	_____
_____	_____	_____

TYPE OF AGENCY (PLEASE CHECK ALL THAT APPLY)

Non-Profit	Proprietary	State or Local Government
____ Church Related	____ Single Proprietorship	____ State
____ Non-Profit Corporation	____ Partnership	____ County/City
____ Other Non-Profit Ownership	____ Corporation	____ Hospital (District Authority)
	____ Hospital/Nursing Facility	

CHECK ANY OF THE FOLLOWING SERVICES YOUR AGENCY PROVIDES:

☐ Durable Medical Equipment ☐ Home Health ☐ Social Work Services ☐ Hospice
☐ Rehabilitation Services ☐ Case Management ☐ Others _____

REQUIREMENTS AND SIGNATURE

Any changes which affect the accuracy of the information on this application must be reported promptly to the Long Term Care Section of the Department of Medical Assistance Services.

Federal requirements stipulate that upon each submission of the provider agreement (or upon actual notice to the provider, whichever is sooner) disclosure of the identity of any person (not limited to but including any owner, operator, manager and/or employee) associated with the agency who has been convicted of a criminal offense (misdemeanor and/or felony) must be made. It is the duty of the provider to make inquiry and screen individuals at the point of application for employment to comply with this section.
Has anyone associated with the agency (owner, operators, managers or employees) been convicted of a criminal offense? **Yes ☐ No ☐**.
If yes, explain the type of offense, name and title of individual:
_____

_____

The signature below certifies the following:

- That the chief administrative agent understands that in order to comply with Federal regulations, it will not charge DMAS a higher rate for Home and Community-Based Care Services than is charged the private sector for the same services

- That there is neither a judgment nor pending action of insolvency or bankruptcy in a State or Federal Court and that the provider of services agrees to inform the Department of Medical Assistance Services (DMAS) immediately if court proceedings to make a judgment of insolvency or bankruptcy are instituted with respect to the provider of services.

- That the chief administrative agent and professional staff have received and reviewed the program description materials of the Home and Community-Based Care services prior to completing this application.

- That the information within this application is accurate, truthful, and complete.

- That DMAS is authorized to make any contact or inquiries necessary to facilitate completion of the application process.

_____ _____
Print Name of person signing application Print title

_____ _____
Signature of person signing contract Date

PART C. CBC PROGRAM STAFF CREDENTIALS AND REQUIREMENTS

COMPLETE FOR ADULT DAY HEALTH CARE
A COPY OF THE DSS ADULT DAY CARE LICENSE MUST BE ATTACHED

You are responsible for assuring that ADHC program staff meet the qualifications detailed in chapter II of the provider manual. All professional staff who perform supervisory/coordinative activities for the ADHC program are expected to be knowledgeable of the ADHC criteria, definitions for the completion of the functional status assessment and all program requirements, regardless of whether they perform these activities on a part time basis. It is the provider's responsibility to assure that any new professional staff are oriented to the program and have the policy, procedures and forms necessary to comply with DMAS requirements. The provider is responsible for instructing all aides who provide ADHC services of the program requirements related to their performance of duties.

1. List below the person who will be responsible for daily management of the Adult day health Care program and who they report to:

_____ _____ _____
Name Title Phone Number
Reports to: _____ _____
Phone Number

_____ _____ _____
Name Title Phone Number
Reports to: _____ _____
Phone Number

2. Complete the following staffing information:

Number of **Program Aides**: _____ full time _____ part time

_____ _____ _____ _____
RN Name License Number Expiration Date Amount/Type
Clinical Experience

Activities Director Name: _____
Post high school education: _____ Number of hours per semester or quarter (circle one).
Obtained at educational institution: _____
Amount and type of experience: _____

Director Name: _____
Post high school education: _____ Number of hours per semester or quarter (circle one).
Obtained at educational institution: _____
Amount and type of experience: _____

3. <u>Hours of Operation</u> **<u>Days of the Week</u>**

_____ _____
_____

Commonwealth Of Virginia
Department of Medical Assistance Services
Medical Assistance Program

Home and Community Based Care Services Participation Agreement
Respite Care

If re-enrolling, enter Medicaid Provider Number here→ _____ Check this box if requesting new number→ ☐

This is to certify:

PAYMENT/CORRESPONDENCE ADDRESS

NAME

ATTENTION

ADDR LINE 1

ADDR LINE 2

CITY, STATE, ZIP

PHYSICAL ADDRESS
(*REQUIRED IF DIFFERENT FROM PAYMENT ADDRESS*)

on this _____ day of _____, _____ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration of Medicaid.

1. **The provider agrees to provide services in accordance with the Provider Participation Standards published periodically by DMAS in the appropriate Provider Manual(s), after being fully certified by DMAS to provide such services. In addition, the provider agrees that all individuals providing services under this Agreement meet the criteria set forth in the above referenced Provider Manual(s).**
2. **Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness condition. In accordance with the terms of Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794) no handicapped individual shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in DMAS.**
3. **The provider agrees to keep such records as DMAS determines necessary. The provider will furnish DMAS on request information regarding payments claimed for providing services under the State Plan. Access to records and facilities by authorized DMAS representatives and the Attorney General of Virginia or his authorized representatives, and authorized federal personnel will be permitted upon reasonable request.**
4. **The provider agrees that charges submitted for services rendered will be based on the usual, customary, and reasonable concept and agrees that all requests for payment will comply in all respects with the policies of VMAP for the submission of claims.**
5. **Payment made under DMAS constitutes full payment on behalf of the recipient except for patient pay amounts determined by DMAS, and the provider agrees not to submit additional charges to the recipient for services covered under DMAS. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a DMAS recipient for any service provided under DMAS is expressly prohibited and may subject the provider to federal or state prosecution.**
6. **The provider agrees to pursue all other health care resources of payment prior to submitting a claim to DMAS.**
7. **Payment by DMAS at its established rates for the services involved shall constitute full payment for the services rendered. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by DMAS, the provider shall reimburse DMAS upon demand.**
8. **The provider agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of DMAS as from time to time amended.**
9. **This agreement may be terminated at will on thirty days' written notice by either party or by DMAS when the provider is no longer eligible to participate in the Program.**
10. **All disputes regarding provider reimbursement and/or termination of this agreement by DMAS for any reason shall be resolved through administrative proceedings conducted at the office of DMAS in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.**
11. **The provider agrees, at all times, to retain full responsibility for any and all performance under this agreement, whether performed by the provider or others under contract to the provider.**
12. **This agreement shall commence on _____. Your participation in the Virginia Medicaid Program is contingent upon the timely renewal of your license. Failure to renew your license through your licensing authority shall result in the termination of your Medicaid Participation Agreement.**

For Provider of Services:

For First Health Services' use *only*	
Director, Division of Program Operations	Date

Original Signature of Provider — Date

Title

_____City or _____County of

IRS Name (required)

IRS Identification Number — (Area Code) Telephone Number

Mail or fax **one** completed **original** agreement to:

First Health - VMAP-Provider Enrollment Unit
PO Box 26803
Richmond, Virginia 23261-6803
1-804-270-7027

Medicare Carrier and Vendor Number

HOME AND COMMUNITY-BASED CARE APPLICATION for PROVIDER STATUS as a RESPITE CARE PROVIDER

Name your agency will do business as: _____

PART A. PREVIOUS PROVIDER EXPERIENCE

3. Type of Related Experience:

I request to be approved as a provider of Respite Care services.
My agency is currently a Virginia Medicaid-enrolled provider of Home Health, Hospital, Rehab, Hospice, Nursing Facility, Clinic or one of the Community-Based Care services.

Yes **No**

Type of Provider _____ Provider ID # _____

Type of Provider _____ Provider ID # _____

Type of Provider _____ Provider ID # _____

4. Please type or print the Administrator's Name:

_____

PART B. GENERAL INFORMATION

In accordance with Federal requirements, all providers of Home and Community-Based Care services must submit the following information to the Department of Medical Assistance Services. The information you provide in this section will help us identify information you send to us, and direct where we send critical information you will need as a provider. Please be sure you follow the directions and accurately note the information requested so that we can provide you with quality service.

ADMINISTRATIVE PERSONNEL ***(Fill in all that apply.)***

_____ _____ _____
Person responsible for signing contract Title Phone number

☐ This person is responsible for general management of requested Medicaid program(s)

Reports to:_____

_____ _____ _____
Chief Administrator On-site Title Phone number

☐ This person is responsible for general management of requested Medicaid program(s)

Reports to:_____

_____ _____ _____
Other On-site Contact Person Title Phone number

☐ This person is responsible for general management of requested Medicaid program(s)

Reports to:_____

_____ _____ _____
Chief Corporate Officer Title Phone number

_____ _____ _____
Other Corporate Contact Person Title Phone number

GEOGRAPHICAL AREAS TO BE SERVED (*See Chapter II for policy re: allowable service area)*

List Cities/Counties in which you intend to serve Medicaid-eligible recipients.

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

OWNERSHIP (FILL IN COMPLETELY FOR ALL OWNERS. INCLUDE PERCENT OF OWNERSHIP OF EACH) For Non-Profit Entities Section 501(c) (3), list the board members.

LEGAL NAME	ADDRESS	%
_____	_____	_____
_____	_____	_____
_____	_____	_____

OWNER(S) PARTICIPATION IN OTHER FEDERALLY FUNDED PROGRAMS

Federal requirements stipulate that any person listed above in with 5 percent or more ownership of any other Medicaid provider or agency that participates in any of the programs established under Title V, XVII, or XX of the Social Security Act must disclose such ownership.

CHECK ONE: _____ N/A _____ APPLICABLE, COMPLETE THIS SECTION

NAME	AGENCY NAME	TYPE OF BUSINESS
_____	_____	_____
_____	_____	_____
_____	_____	_____

TYPE OF AGENCY (PLEASE CHECK ALL THAT APPLY)

Non-Profit	Proprietary	State or Local Government
____ Church Related	____ Single Proprietorship	____ State
____ Non-Profit Corporation	____ Partnership	____ County/City
____ Other Non-Profit Ownership	____ Corporation	____ Hospital (District Authority)
	____ Hospital/Nursing Facility	

CHECK ANY OF THE FOLLOWING SERVICES YOUR AGENCY PROVIDES:

Durable Medical Equipment Home Health Social Work Services Hospice
Rehabilitation Services Case Management Others _____

REQUIREMENTS AND SIGNATURE

Any changes which affect the accuracy of the information on this application must be reported promptly to the Long Term Care Section of the Department of Medical Assistance Services.

Federal requirements stipulate that upon each submission of the provider agreement (or upon actual notice to the provider, whichever is sooner) disclosure of the identity of any person (not limited to but including any owner, operator, manager and/or employee) associated with the agency who has been convicted of a criminal offense (misdemeanor and/or felony) must be made. It is the duty of the provider to make inquiry and screen individuals at the point of application for employment to comply with this section.
Has anyone associated with the agency (owner, operators, managers or employees) been convicted of a criminal offense? **Yes No** .
If yes, explain the type of offense, name and title of individual:

_____

_____

The signature below certifies the following:

- That the chief administrative agent understands that in order to comply with Federal regulations, it will not charge DMAS a higher rate for Home and Community-Based Care Services than is charged the private sector for the same services

- That there is neither a judgment nor pending action of insolvency or bankruptcy in a State or Federal Court and that the provider of services agrees to inform the Department of Medical Assistance Services (DMAS) immediately if court proceedings to make a judgment of insolvency or bankruptcy are instituted with respect to the provider of services.

- That the chief administrative agent and professional staff have received and reviewed the program description materials of the Home and Community-Based Care services prior to completing this application.

- That the information within this application is accurate, truthful, and complete.

- That DMAS is authorized to make any contact or inquiries necessary to facilitate completion of the application process.

_____ _____
Print Name of person signing application Print title

_____ _____
Signature of person signing contract Date

PART C. CBC PROGRAM STAFF CREDENTIALS AND REQUIREMENTS

COMPLETE FOR RESPITE CARE

You are responsible for assuring that RN supervisory and aide staff meet the qualifications detailed in chapter II of the provider manual. All RN's who perform supervisory activities for the respite care program are expected to be knowledgeable of the respite care criteria, definitions for the completion of the functional status assessment and all program requirements, regardless of whether they perform these activities on a part time basis. It is the provider's responsibility to assure that any new RN staff who provide RN supervision for the respite care program are oriented to the program and have the policy, procedures and forms necessary to comply with DMAS requirements. The provider is responsible for instructing all aides who provide respite care in the program requirements related to their performance of duties.

1. **List below the person who will be responsible for daily management of the Respite Care program and who they report to:**

_____ _____ _____
Name Title Phone Number
Reports to: _____ _____
Phone Number

_____ _____ _____
Name Title Phone Number
Reports to: _____ _____
Phone Number

2. **Indicate the number of staff, both full time (FT) and part time (PT) you currently have hired to provide Respite Care.**

# FT	# PT		# FT	# PT	
___	___	**Registered Nurses**	___	___	**Respite care Aides**

3. **Complete the following for each RN who will provide supervision, on either a full time or part time basis. In the FT/PT column, indicate the percent of time the RN will devote to the Respite Care program.**

Name	FT/PT	License #	Expiration Date	Amount/Type Clinical Experience

Commonwealth of Virginia
Department of Medical Assistance Services
Medical Assistance Program

Durable Medical Equipment and Supplies Participation Agreement

If re-enrolling, enter Medicaid Provider Number here→ _____ Check this box if requesting new number→ ☐

This is to certify:	**PAYMENT/CORRESPONDENCE ADDRESS**	**PHYSICAL ADDRESS (*REQUIRED IF DIFFERENT FROM PAYMENT ADDRESS*)**
NAME		
ATTENTION		
ADDR LINE 1		
ADDR LINE 2		
CITY, STATE, ZIP		

on this _____ day of _____, _____ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration of Medicaid.

Supplies dispensed require a Virginia Department of Health Professions Permit? One of the boxes must be checked.

☐ No. Copy of business license is enclosed.
☐ Yes. Pharmacy or Medical Equipment Supply DHP permit number is listed in the appropriate field below.

1. **Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. No handicapped individual shall, solely by reason of his handicap be excluded from participation in, be denied the benefits of, or be subjected to discrimination in Section 504 of the Rehabilitation Act of 1973 (29 §USC 794) VMAP.**
2. **Services rendered must be those provided according to a physician's written order. Payment is to be made only to those providers who actually render the services. Upon accepting a Medicaid recipient as a patient, the provider agrees to supply all items prescribed and authorized for the recipient which the provider supplies to the general public.**
3. **The provider agrees to keep such records as VMAP determines necessary. The provider will furnish VMAP on request information regarding payments claimed for providing services under the state plan. Access to records and facilities by authorized VMAP representatives, the Attorney General or his authorized representatives, and federal personnel will be permitted under reasonable request.**
4. **The provider agrees that charges submitted for services rendered will be based on the usual, customary, and reasonable concept and agrees that all requests for payment will comply in all respects with the policies of VMAP for the submission of claims.**
5. **Payment by VMAP at its established rates for services covered constitutes full payment on behalf of the recipient. The provider agrees not to submit additional charges to the recipient for services covered by VMAP. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a medical assistance recipient for any service provided under medical assistance is expressly prohibited.**
6. **The provider agrees to pursue all other available third party payment sources prior to submitting a claim to VMAP.**
7. **Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by VMAP, the provider will reimburse VMAP upon demand.**
8. **The provider agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of VMAP as from time to time amended.**
9. **The provider of respiratory ventilator equipment agrees to provide authorized maintenance and preventive services for ventilators belonging to VMAP recipients.**
10. **This agreement may be terminated at will on thirty days' written notice by either party or by VMAP when the provider is no longer eligible to participate in the Program.**
11. **All disputes regarding provider reimbursement and/or termination of this agreement by VMAP for any reason shall be resolved through administrative proceedings conducted at the office of VMAP in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.**

12. This agreement shall commence on _____. Your continued participation in the Virginia Medicaid Program is contingent upon the timely renewal of your license. Failure to renew your licensing authority shall result in the termination of your Medicaid Participation Agreement.

For Provider of Services:

For First Health's use only

Director, Division of Program Operations Date

Original Signature of Provider **Date**

_____City or _____County of _____

IRS Identification Number **(Area Code) Telephone Number**

Pharmacy Permit Number (VA Board of Pharmacy) ***OR*** **DME Permit Number (VA Board of Pharmacy)**

IRS Name (required)

mail **one** completed **original** agreement to: **First Health - VMAP-Provider Enrollment Unit**
PO Box 26803
Richmond, Virginia 23261-6803

Medicare Carrier and Vendor Number

PERSONAL CARE AIDE TRAINING COURSE OUTLINE

I. THE AGENCY, THE PROVIDER, AND THE COMMUNITY

A. Introduction to the Agency

1. Structure of organization
2. Overall programs of the agency
3. Agency policies and procedures (e.g., payroll, record keeping, travel and meal expenses, requirements of dress, confidentiality, ethics)

B. Introduction to Personal/Respite Care Services

1. Definition and objectives of the services
2. The team approach to provision of services
   a. Personnel involved (e.g., supervisor, client, physician)
   b. Roles and relationships of personnel involved
3. Role of aide in the provision of services

C. Introduction to the Community

1. Community resources available
2. Relationship to other agencies

II. THE ELDERLY

A. Physical and Psychological Aspects of Aging

B. Physical and Emotional Needs of the Elderly

C. Types of Common Health Problems

D. Types of Situations in Which the Personal/Respite Care Aide May Be Involved

E. Physical Factors of Special Importance to the Elderly

F. Concepts of Work and the Elderly

III. THE PHYSICALLY ILL AND DISABLED

A. Effects of Illness on the Family

1. Financial
2. Psychological
3. Behavioral

B. Effects of Chronic Illness on the Way an Individual Feels About Himself or Herself

C. Individual Reactions to Illness

1. Between family
2. Between individuals

D. Orientation to Types of Physical Disabilities or Handicaps Which May Be Encountered

1. Rheumatoid arthritis
2. Stroke
3. Heart trouble

IV. PERSONAL CARE AND REHABILITATIVE SERVICES

A. Body Mechanics

1. Importance of body mechanics to the personal care aide and client
2. Limitations on the personal care aide to activities
3. Techniques of body mechanics
    a. Helping the client sit up in bed
    b. Moving the client in bed
    c. Helping the client move from:
        1. Bed to chair and return
        2. Bed to wheelchair and return
        3. Bed to toilet or commode and return
        4. Bed to tub or shower and return
        5. Chair to commode and return
        6. Chair to tub and return
        7. Wheelchair to tub and return
        8. Wheelchair to commode and return
    d. Helping the client walk with walker, crutches, and cane

B. Personal/Respite Care

1. Importance of personal/respite care activities to the client
2. Limitations on the personal/respite care aide's activities
    a. Importance of understanding
    b. Policies and procedures regarding requests for unauthorized activities
3. Techniques of personal care
    a. Assisting the client with eating
    b. Assisting the client with dressing
    c. Mouth care
    d. Hair care
    e. Shaving male patients
    f. Fingernail care, toenail care
    g. Bathing, tub, shower, bed
    h. Bed-making with and without the patient in bed
    i. Elimination
    j. Back rub

V. HOME MANAGEMENT

A. Care of the Home and Personal Belongings

1. Importance of maintaining a clean environment
2. Preparation of housekeeping tasks
    a. Scheduling of tasks
    b. Types of cleaning and laundry supplies
    c. Organization of supplies and equipment
    d. Use of proper body mechanics
3. Routine care and use of:
    a. Cleaning equipment
    b. Laundry equipment

c. Kitchen equipment
4. Emergencies related to:
   a. Heating equipment
   b. Water supply
   d. Electricity
5. Care of furniture
6. Repair of clothing and linen
7. Pest control
8. Care of an individual's environment

VI. SAFETY AND ACCIDENT PREVENTION IN THE HOME

A. Common Types of Accidents

B. Accident Prevention

1. Typical hazards in the home
   a. Bathroom
   b. Kitchen
   c. Stairway
   d. General
2. Ways to safety-proof the home

C. Policies and Procedures Regarding Accidents or Injuries in the Home to Self and Client

1. Limitations of the aide
2. Techniques of simple first aid
   a. Treatment of abrasion
   b. Treatment of abrasions, cuts, bruises
   c. Treatment of first and second degree burns
   d. Poisoning
3. Medical and fire emergencies

VII. FOOD, NUTRITION, AND MEAL PREPARATION

A. Importance of Nutrition to the Individual

B. General Concept of Planning Meals

1. Nutritional value
2. Cultural and ethnic food patterns
3. Individual likes and dislikes
4. Budgetary limitations

C. Special Considerations of Normal Diet:

1. Elderly
2. Ill

D. Special Considerations in Preparation of Special Diets

1. Importance of special diets
2. Common types of special diets
3. Policy and procedure regarding the aide’s activities in relation to special diets

E. Food Purchasing and Preparation

1. Buying guides
2. Techniques of food preparation

F. Food Storage and Sanitation

ADULT DAY HEALTH CARE PROGRAM AIDE TRAINING

I. THE ADULT DAY HEALTH CARE CENTER

A. Organization of the center

1. Purpose and philosophy of the center
2. Brief history of center
3. Organization chart (staff, administration, board, volunteers, interns)
4. Center relationships and networks with other agencies

B. Program aide position

1. Position description (role, duties, qualifications)
2. Personnel policies and procedures relevant to aide position (payroll, dress requirements, ethics, confidentiality, Leave/policies, hours)
3. Supervisory relationships, methods and expectations
4. Performance evaluation (methods, frequency)
5. Multidisciplinary team

C. Physical plant and safety

1. Physical layout of center (rooms/uses, exits, phones, storage, outdoor space, parking, restricted areas, bathrooms, offices)
2. Building safety (keys, locked areas, fire extinguishers, fire alarms/smoke detectors, ramps, stairways, elevators, lighting, exit alarm system)
3. Safety procedures (fire drills, emergency numbers, first aid supplies, procedure for notifying supervisory staff of an emergency; aide role in fire, participant accident or illness emergency; providing information for documenting accidents)
4. Accident prevention
    a. Common types of accidents in ADHC
    b. Participant risk factors leading to accidents (vision and hearing loss, mobility problems, confusion, agitation, wandering, incontinence)
    c. Environmental risk factors (floors, steps, curbs, nonedibles, sharps, hot items, unsupervised smoking, noise/confusion, level of supervision)
    d. Limitations of aide
    e. Techniques of simple first aid
        1. Treatment of abrasion
        2. Treatment of abrasions, cuts, bruises
        3. Treatment of first and second degree burns
5. Housekeeping responsibilities
    a. Shared by all staff
    b. Unique to aide

II. ADULT DAY HEALTH CARE PARTICIPANTS

A. General characteristics of elderly

1. Normal physical aging
2. Normal psychological developments
3. Normal cognitive change
4. Myths and stereotypes about aging
5. Personal/social issues of concern to elderly
    a. Living arrangements
    b. Family relationship
    c. Income changes
    d. Maintaining maximal independence in self-care
    e. Socialization needs
    f. Work role substitutes
    g. Support needs and options

B. Characteristics of adult day health care participants

1. Orientation to disabilities frequently encountered in ADHC
    a. Alzheimers and other dementias
    b. Stroke
    c. Parkinsonism
    d. Depression
    e. Diabetes
    f. Heart conditions
    g. Arthritis
    h. Vision and hearing loss; sensory loss
    i. Respiratory diseases
2. Functional effects of aging/disability on ADHC participant
    a. Effect on self-concept
    b. Effect on relationships
    c. Effect on self-care
    d. Effect on mobility
    e. Effect on roles and activities
    f. Effect on living arrangements
    g. Effect on income and expenses
3. Emotional needs of ADHC participants
    a. Esteem
    b. Purpose
    c. Individuality
    d. Security
    e. Support
    f. Stimulation

C. Family of ADHC Participants

1. General introduction to family systems theory
2. Purposes of ADHC for family

3. Family attitudes about ADHC
4. Family reactions to aging/disability
5. Needs of family members
    a. Physical and emotional support
    b. Affirmation
    c. Information/education
    d. Referral
    e. Respite
    f. Limits
6. Relating to ADHC families
    a. Importance of frequent communication
    b. Family expectations of staff
    c. Staff expectations of family

D. Participant Rights

III. ADULT DAY HEALTH CARE SERVICES

A. Personal Care – overview of aide's role

1. Toileting
    a. Providing physical assistance
    b. Dealing with confusion
    c. Equipment/supplies
    d. Reporting problems
    e. Charting output
2. Hygiene
    a. Hygiene needs in ADHC
    b. Equipment/supplies
    c. Reporting problems
3. Dressing
    a. Techniques related to selected disabilities (hemiparesis, confusion, blindness, arthritis)
    b. Procedures for storing extra clothing, coat, personal items
4. Mobility and body mechanics
    a. Importance of body mechanics
    b. Common mobility problems in ADHC
    c. Transfer techniques
        1. Chair to standing and return
        2. Bed to standing and return
        3. Standing to toilet and return
        4. Wheelchair transfers to and from chair, toilet, bed
        5. Tub/shower transfers, if applicable
    d. Mobility aids
        1. Wheelchair
        2. Walker
        3. Quad cane
        4. Orthopedic cane

e. Special mobility issues for visually and hearing impaired and confused participants

5. Standard precautions

B. Meals

1. Importance of good nutrition
2. Meal pattern in ADHC
3. Overview of special diets served
4. Dietary precautions/prohibitions
   a. Diabetic
   b. Salt restricted
   c. Bland
   d. Low cholesterol
   e. Weight loss/gain
   f. Dental soft
5. Meals/eating problems common in ADHC; management techniques
   a. Poor appetite
   b. Excessive appetite (dementia)
   c. Sharing food
   d. Need for physical assistance, equipment, encouragement
   e. Individual likes and dislikes
   f. Food allergies
   g. Choking and swallowing problems
   h. Dentures/edentulous
6. Reporting eating problems
7. Snacks
   a. Snack menu
   b. Purposes for serving snacks
   c. Aide role in snack planning, preparation, serving, clean-up
   d. Snack portions/frequency (including coffee, tea)

C. Therapeutic activities

1. Purpose of activities in ADHC
2. Types of activities (social, recreational, educational, spiritual)
3. Importance of balance in work, rest and play
4. Aide role in activity programming
5. Orientation to specific activities and their adaptation for various disabilities
   a. Exercise
   b. Games
   c. Discussion/support groups
   d. Crafts
   e. Outings
   f. Other individual and group activities
6. Motivating participants to become/remain active
7. Safety precautions for selected activities
8. Storage and maintenance of activity supplies and equipment

D. Therapeutic milieu

1. Concept of therapeutic milieu
2. ADHC center as a milieu
3. Useful therapeutic approaches in ADHC milieu
    a. Structure
    b. Affection/positive regard
    c. Touch
    d. Humor
    e. Set limits
    f. Personal space
    g. Personal time
    h. Reality orientation
    i. Reminiscing
    j. Outlets for anxiety and anger
    k. Walking/pacing
    l. Use of voice
    m. Redundant cueing
    n. Use of gestures and body language

E. Health and restorative services

1. Overview of services provided by health/rehabilitation staff
2. Aide role in reinforcing and augmenting services

F. Transportation

1. Methods of transporting participants between home and center
2. Aide role in transportation system
3. Dealing with participants' physical, emotional and cognitive concerns about transportation arrangements

G. Documentation of services

1. Purpose of documentation
2. ADHC procedures for documentation
3. Aide role in documentation
4. Aide access to participant records
5. Review of confidentiality related to records

H. Termination of ADHC services

1. Common reasons for discharge from ADHC
2. Participant and staff preparation for anticipated discharge
3. Special considerations in unanticipated discharge
4. Aide feelings about "loss" of participant

First Health
Services Corporation

MAILING SUSPENSION REQUEST
SERVICE CENTER AUTHORIZATION
SIGNATURE WAIVER
PHARMACY POINT-OF-SALE

Please review and check the blocks which pertain to you:

- ☐ **MAILING SUSPENSION REQUEST:**
  I do not wish to receive Medicaid memos, forms, or manual updates under the Medicaid provider number given below.

- ☐ **COMPUTER GENERATED CLAIMS:**
  I certify that I have authorized the following service center to submit computer-generated invoices (by modem, diskette or tape) to Virginia Medicaid:

  _____
  (Service Center Preparing Invoices)

  Service center code: _____ **Magnetic Tape RA:** YES NO (Circle One)

  Prior service center code: _____

- ☐ **SIGNATURE WAIVER:**
  I certify that I have authorized submission of claims to Virginia Medicaid which contain my typed, computer generated, or stamped signature.

- ☐ **PHARMACY POINT-OF-SALE AUTHORIZATION (in-state providers only):**
  I wish to submit Point-of-Sale billings to Virginia Medicaid.

I understand that I am responsible for the information presented on these invoices and that the information is true, accurate, and complete. I further understand that payment and satisfaction of these claims will be from federal and state funds and that false claims, statements, documents, or concealment of material facts may be prosecuted under applicable federal and state laws.

PROVIDER NAME: _____

PROVIDER NUMBER: _____ Leave blank, if number pending.

SIGNATURE: _____

DATE: _____

TELEPHONE # _____

Please return completed form to:

First Health
VMAP-PEU
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Richmond, Virginia 23261-6803
1-804-270-5105